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Unit #15237
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Medical Services

FORCE HEALTH PROTECTION (FHP) REQUIREMENTS FOR DEPLOYMENTS AND TRAVEL TO THE KOREAN THEATER OF OPERATION DURING ARMISTICE

***This regulation is the first edition.**

FOR THE COMMANDER:

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Summary. This regulation establishes policies, procedures and assigns responsibilities for Force Health Protection (FHP) in the United States Forces Korea (USFK) and the Korean Theater of Operation (KTO) during armistice operations. This regulation is to serve as a minimum requirement in order for all personnel to meet or exceed an optimal status of deployment and highest possible level of FHP. Component Commanders may require additional preventive measures in order to meet specific medical threats and challenges as necessary.

Applicability. In accordance with (IAW) JCS MCM 0028-07, Procedures for Deployment Health Surveillance, 2 November 2007, DoDD 6200.04, Force Health Protection, DoDI 6490.03, Deployment Health, PACOM FHP Guidance of October 2014, DoDI 6490.02, Comprehensive Health Surveillance, this regulation applies to all USFK Service Components, Department of Defense (DoD) military, and government service civilians on official travel, deployment and permanent change of station (PCS) orders. This regulation also applies to non-DoD interagency personnel who have been appointed to USFK Headquarters, and DoD contractor personnel traveling or deploying with U.S. Forces within the KTO. However, DoD contractor personnel are

only included to the extent provided in applicable contracts or IAW DoD and Service-specific policy. Shipboard operations that are not anticipated to involve movement ashore are exempt from the deployment requirements of this regulation except when potential health threats indicate actions necessary beyond the scope of shipboard occupational health programs.

Supplementation. Issue of further supplements to this regulation by subordinate commands is prohibited unless prior approval is obtained from Headquarters (HQ) USFK Surgeon (FKSG), Unit #15237, APO AP 96205-5237, email: fksg@korea.army.mil.

Forms. USFK forms are available at http://www.usfk.mil.

Records Management. Records created as a result of processes prescribed by this regulation must be identified, maintained, and disposed of according to AR 25-400-2. Record titles and descriptions are available on the Army Records Information Management System website at: https://www.arims.army.mil.

Suggested Improvements. The proponent of this regulation is Office of the Command Surgeon, HQ USFK Surgeon (FKSG). Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to HQ USFK Surgeon (FKSG), Unit #15237, APO AP 96205-5237, email: fksg@korea.army.mil.

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Chapter 1
Introduction

1-1. Purpose
To establish a FHP program and set requirements to effectively anticipate, recognize, evaluate, control and mitigate health threats to personnel operating in the Korean Theater of Operation (KTO).

1-2. References
Required and related publications are listed in appendix A.

1-3. Explanation of Abbreviations and Terms
Abbreviations and terms used in this regulation are explained in the glossary.

1-4. Overview
This regulation pertains to deployment health activities taken before assignment to USFK, Component Commands or the supporting commands; before official travel to the Korean Theater of Operations (KTO); and before, during, and after deployments. For purposes of this regulation, per Joint Publication 1-02, deployment is defined as: "The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intra-continental United States, intertheater, and intratheater movement legs, staging and holding areas." This regulation applies to FHP requirements and deployment health activities during armistice.

1-5. Force Health Protection
The USFK FHP program is a comprehensive framework of deployment health activities that aims to; 1) prevent casualties resulting from disease and injuries (DI), 2) identify and prevent exposures to occupational and environmental threats, and 3) implement an inclusive health surveillance system for early identification of health threats within the KTO to prevent, neutralize, minimize or altogether eliminate the hazard.

a. Health surveillance is a critical component of the USFK FHP program. It includes occupational and environmental health surveillance and medical surveillance subcomponents. Specifically, through health surveillance activities, disease, occupational and environmental health (OEH) hazards are quickly identified, assessed and documented to include chemical, biological, radiological and nuclear (CBRN) risks and exposures.

b. U.S. Army Public Health Command (USAPHC) is the repository for operational and deployment health surveillance and reports for the KTO. Occupational and environmental health surveillance data and reports (food and water assessment reports, vector analysis, environmental sampling and occupational exposure data) with the exception of surveillance data generated from the Joint USFK Portal and Integrated Threat Recognition (JUPITR) system, will be captured and managed by the Defense Occupational and Environmental Health Readiness System (DOEHRS).

1-6. Responsibilities

a. USFK Surgeon (FKSG). Has overall staff responsibility for ensuring FHP requirements of this regulation are met and synchronized in all OPLANS and among the Service Component health service support plans. Further, FKSG will:

(1) Ensure that the policies of this regulation are executed throughout all applicable operations.

(2) Establish a Joint FHP working group to meet quarterly to review current deployment health guidance from higher headquarters. In addition, the group will review lessons learned and after action report (AAR) items from past deployments and exercises highlighting successes, problems, and solutions. The group will develop and recommend changes to this regulation, as appropriate.

(3) Ensure deliberate and crisis action plans address FHP requirements.

(4) Ensure subordinate medical activities conduct a standardized, comprehensive and timely program of surveillance, assessment and prevention of health hazards, based upon the threat assessment and guidance provided in this regulation to include DI, reportable medical events (RME), occupational and environmental health site assessments (OEHSA), occupational and environmental health surveillance (OEHS), and medical surveillance.

(5) Ensure occupational safety and health programs are implemented.

(6) Ensure DoD environmental health reporting systems and procedures are maintained for appropriate reporting and archiving of health surveillance and environmental data and reports (OEHSA, OEHS data). Special attention is needed to ensure individual exposure records can be linked to individual health records.

(7) Ensure that human health risk assessments and environmental hazard studies are continuously reviewed and updated throughout all phases of deployment using data collection capabilities of organic preventive medicine units and specialized units. Support deployment data collection through the Deployment Environmental Surveillance Program (DESP), United States Army Public Health Command (USAPHC).

(8) Use the armed forces preventive medicine recommendations as distributed by the National Center for Medical Intelligence (NMCI) in planning scenario-specific medical requirements and determining appropriate preventive countermeasures.

(9) Request deployment of technically specialized units, as required, to conduct surveillance for occupational and environmental illnesses, injuries, diseases, health hazard assessments, and advanced diagnostic testing. These units shall conduct health assessments of potential exposure to biological, chemical, or physical agents that threaten the health and safety of deployed personnel.

(10) Forward medical lessons learned to the Joint Uniform Lessons Learned System (JULLS) and to other appropriate service lessons learned systems to improve subsequent preventive medicine support of operations.

b. Director for Manpower, Personnel, and Administration (J1).

(1) Provide a daily location recording for all deployed personnel assigned, attached, on temporary duty (TDY), or temporary additional duty (TAD) to deployed units.

(2) Establish the requirement for Service Components and each deployed unit to establish, maintain, and report daily accountability (or when changes in location occur) of all USFK personnel assigned, attached, on TDY or TAD to the unit, along with their once-daily location record.

(3) As required by exercise directive (EXDIR) or deployment orders (DEPORDS), ensure personnel process through the Joint Personnel Reception Center (JPRC) for review of medical readiness status, Force Health Protection Prescription Products (FHPPP), immunization record and issuance of required prophylactic medications.

(4) Ensure all USFK DEPORDS, PCS and TAD/TDY travel orders for the KTO contain the following statement verifying compliance with this regulation:

"*Individual(s) received medical screening, briefing, medications and immunizations for travel IAW USFK Reg XX-XXX.*"

(5) Manage casualty operations and reporting requirements and provide timely and accurate notification to the appropriate ground component commander (GCC) and subordinate Joint Force Commanders (JFC) to make them aware of any medical event that may have an operational impact on the status of forces.

c. Director for Intelligence (J2).

(1) Coordinate medical intelligence information with FKSG Office/J4 HSS.

(2) Review plans to ensure they describe procedures for collecting and analyzing intelligence information that potentially impacts the health and safety of USFK personnel.

(3) Ensure dissemination of procedures for the collection and analysis of health threat and hazard information to FKSG and USFK Service Components.

(4) In coordination with the Defense Intelligence Agency and National Center for Medical Intelligence (NCMI), provide intelligence information specific to the KTO pertaining to Component Services in support of their deployment health surveillance responsibilities when requested.

d. Director of Operations (J3).

(1) Assist Director for Strategy, Planning and Policy (J5) in ensuring deliberate and crisis action plans address FHP and deployment health surveillance requirements.

(2) Coordinate with the FKSG and/or FHP Officer regarding suspected and confirmed CBRN incident exposures to facilitate personnel tracking of known or potentially exposed personnel.

e. Director of Logistics (J4).

(1) Factor preventive medicine personnel and equipment requirements for performing deployment health surveillance activities into time-phased force and deployment data (TPFDD) planning.

(2) Ensure FHP personnel are included in contracted-service provision reviews to make certain FHP requirements are properly planned for.

f. Director of Strategy, Policy and Plans (J5). Ensure deliberate and crisis action plans address FHP and OEHS requirement specifically food/water vulnerability assessments, OEHSA, CBRNE and OEH incidents and RME reporting and documentation.

g. Director of Command, Control, Communications and Computers (J6). Provide appropriate communication capability to medical units within the KTO to facilitate medical reporting requirements and medical intelligence information dissemination.

h. Commander, Eighth Army, Commander, 7th United States Air Force (7AF), Commander, Naval Forces Korea (CNFK) and Commander, Marine Forces Korea (MARFORK).

(1) Review medical records of all PCS personnel upon in-processing for medical readiness status and immunization compliance. Provide immunizations and/or chemoprophylaxis as needed.

(2) Provide a quarterly medical readiness roll-up report to the FKSG of number of personnel not current on immunizations or having medical and dental conditions that places them in a non-ready status.

(3) Provide immunizations, chemoprophylaxis and examinations of personnel arriving at RSOI sites, military treatment facilities (MTF) or Joint Personnel Reception Center (JPRC).

(4) Ensure all patient encounters are documented. Maintain all inpatient and original outpatient medical encounter documentation and incorporate into the deployment health record (automated or hardcopy; DD form 2766 or equivalent).

(5) Conduct food and water vulnerability assessments for bases with Base Operating Support (BOS) responsibilities IAW Service Standards. Ensure assessments validate potential or actual vulnerabilities to determine courses of action and reduce identified risks.

(6) Be prepared to conduct ongoing DI surveillance and provide DI summary reports and RME data weekly to FKSG when requested.

1-7. Theater-Wide FHP Preparedness for Deployments and Travel

USFK, through deployment orders and/or separate instructions, will require the Components or supporting Commanders to accomplish the following at the home station or processing station of the deploying Service member or unit, or as part of the deliberate or crisis planning effort:

a. Establish requirements, allocate and assign appropriate medical and OEH surveillance resources to meet anticipated deployment needs, particularly in the earliest operational phases.

b. Based on pre-deployment assessment during the planning process, USFK Service Components will develop and maintain appropriate OEH surveillance and monitoring programs for deployments. If the resource requirements are beyond the capabilities of organic preventive medicine assets, the required capability must be programmed into the force flow for technically specialized units to perform these functions in the KTO.

c. Conduct studies at potential deployment sites to establish pre-deployment occupational and environmental health baseline conditions whenever feasible.

d. Complete risk assessments for all known health hazards IAW Service operational risk management guidance. Incorporate Health Risk Assessments into overall operational plans and specify requirements for risk control decisions by the appropriate level in the command.

e. Inform Service Members on all known potential health threats, including endemic diseases; entomological hazards; potential injuries; chemical, biological, radiological or nuclear (CBRN)

contaminants; toxic industrial materials (agricultural and industrial); deployment related stress; and climatic/environmental extremes (e.g., heat, cold, high altitude, wind-blown sand and dirt).

f. Proven preventive medicine countermeasures will be employed, to include avoidance of hazardous locations when consistent with operational goals, appropriate personal protective measures, and the use of personal protective equipment when appropriate.

g. Maintain Individual Medical Readiness (IMR) of Component forces that meets or exceeds Service medical readiness requirements so unit movement is not delayed and deployment limiting conditions are minimized.

Chapter 2
Pre-Deployment and Pre-Travel Force Health Protection Requirements

2-1. General
Pre-deployment health activities are based on the deployment type, the Commander's decision, DoD and Service policies, and the health risk assessments for the KTO. Amplifying and additional FHP requirements will be published as determined by the operational environment.

a. These FHP requirements may be used as guidance for accompanying family members and other categories of personnel not previously mentioned as determined by the senior Preventive Medicine Authority, 65th Medical Brigade/Force Health Protection Director

b. USFK and service component personnel serving in deployment status must undergo a medical assessment prior to assignment in accordance with DoDI 6490.03, Deployment Health. The mandatory portions of the assessment are:

(1) DD Form 2795, Pre-Deployment Health Assessment and DD Form 2766, Adult Preventive and Chronic Care Flow-Sheet must accompany all individuals deployed to the KTO for 90 days or greater. Completed copies of these forms must be submitted to the Defense Medical Surveillance System (DMSS) and included in DoD personnel deployment paperwork. They will serve as the deployment medical record.

(2) Medical record review.

(3) Current periodic health assessment.

(4) For DoD civilian employees, a physical exam within 1 year of assignment is required.

c. All personnel, either deployed or TAD/TDY greater than 30 days, or on PCS orders in support of the USFK mission must be assessed and determined to be fully medically ready, psychologically fit for worldwide assignment and travel and meet the following minimum FHP requirements:

(1) Current on immunizations and meet medical readiness requirements per this Regulation.

(2) At a minimum, screening using a risk questionnaire for latent tuberculosis (TB) infection (LTBI) must be performed and documented for all personnel on PCS or deployment orders 90 days prior to arriving, and again 90 days after permanently departing the KTO and returning to CONUS or OCONUS location with a low prevalence of active TB. Only those with high-risk responses will

be skin tested for LTBI. Individuals who will be in Korea for more than two years will be screened annually using a risk questionnaire and only those with high-risk responses will be skin tested for LTBI. NOTE: Service Component Surgeons may require skin testing for LTBI in lieu of screening for personnel on PCS or deployment orders 90 days prior to arriving, and again 90 days after permanently departing the KTO and returning to CONUS. See Section 3, Disease Threats and Countermeasures, paragraph d. for TB risk in the Republic of Korea (ROK).

(a) The purpose for testing is to rule out active and/or previously unidentified latent TB in order to ensure adequate treatment and to document a negative test in order to detect a subsequent conversion at the time of post-deployment testing.

(b) One of two tests may be used for TB screening: a tuberculin skin test (TST), or Interferon-Gamma Release Assay (IGRA, i.e., Quantiferon Gold). However, if TST is used, IGRA should not be used to confirm or verify the TST result.

(c) TB convertors who have had a prior evaluation and appropriate management are not prohibited from permanent assignment to USFK or excluded from deployment, PCS or TAD/TDY.

(d) Personnel who have converted positive within three months of assignment to USFK must be medically evaluated and cleared of active TB and be current in preventive therapy before transfer or deployment to the KTO.

2-2. Medical Readiness, Immunizations and Force Health Protection Prescription Products (FHPPP)

Medical Readiness, Immunizations and FHPPP are important aspects of the USFK FHP Program. Nothing in this regulation precludes either the assignment or deployment of personnel to the KTO during armistice for active duty or emergency essential civilians (EEC) who are found to be medically exempt from administration of a mandatory immunization or FHPPP. Other measures to protect these individuals are available and will be implemented to the fullest extent to protect them.

a. Medical Readiness Requirements:

(1) Periodic Health Assessment (PHA) or physical examination IAW Service-specific policy that will remain current for the anticipated duration of deployment or travel. Individuals on PCS orders must comply with USFK Regulation 40-7, Individual Medical Readiness(IMR) throughout their assignment.

(2) All individual medical readiness deficiencies and deployment-specific health readiness deficiencies must be corrected before assignment or deployment and documented in the Service's electronic tracking system for individual medical readiness requirements IAW with DoDI 6025.19, Medical Readiness.

(3) For deployed/rotational forces, a mental health readiness assessment and baseline pre-deployment neurocognitive assessment is required IAW criteria outlined in DoDI 6490.13, Comprehensive Policy on Neurocognitive Assessments by the Military Services.

(4) No deployment limiting conditions as defined by DoDI 6490.07, Service-specific policy and this regulation. Individuals with deployment limiting conditions may deploy or travel with a medical waiver as outlined in this regulation.

(5) Dental Class I or II per current annual exam, which will remain current for the anticipated duration of assignment, deployment or travel.

(6) Deployment readiness lab studies:

(a) DNA on file.

(b) Human Immunodeficiency Virus (HIV) test within 24 months of deployment or PCS. Civilian screening will be conducted IAW Service-specific policy.

(c) G6PD deficiency test status on file.

(d) Pre-deployment serum specimen for medical examination must be collected within 12 months of deployment or assignment IAW DoD policy.

(e) Pregnancy testing will be accomplished IAW Service-specific policy.

(7) Individual Medical Readiness equipment. Service members must deploy and PCS with:

(a) Prescription medications: personal prescription medication supplies to last the duration of deployment or PCS travel and in-processing time.

(b) Medical equipment: all required medical equipment (2 pairs of eyeglasses, orthodontic items, hearing aids and batteries, etc).

(c) Personal durable medical equipment for certain health conditions will be allowed IAW medical waiver.

(d) Any occupational health PPE (respiratory and hearing protection, dosimeters, etc).

(e) Medical Alert tags: individuals requiring medical alert tags will deploy and PCS with red medical alert tag worn in conjunction with their personal identification tags.

(f) Contact lenses: IAW Service-specific policy.

b. Vaccination requirements for PCS, TAD/TDY and deployed personnel. Table 2-1 is a summary of immunization requirements and recommendations.

(1) As a general rule, no required immunization will be deferred until arrival into KTO. If unavoidable circumstances preclude administering all immunizations in a series, at least the first dose (see anthrax exception below) in the series must be given prior to deployment or PCS, with arrangements coordinated for the subsequent immunizations to be given upon arrival/at RSOI site. Component commands will report immunization data through Service-specific immunization tracking systems. Entering immunization data promptly into electronic tracking systems is essential to optimize the service member's personal protection and to prevent duplication of immunizations.

(2) Hepatitis A vaccine (series complete, or at least one dose prior to deployment/assignment).

(3) Hepatitis B vaccine (series complete, or at least one dose prior to deployment/assignment).

(4) Polio and Measles/Mumps/Rubella vaccine or documentation of immunity.

(5) Varicella is required for personnel without evidence of immunity to varicella. Evidence of immunity in adults includes any of the following:

(a) Documentation of 2 doses of varicella vaccine 4 weeks apart.

(b) Citizens born before 1980 (not for healthcare personnel).

(c) History of varicella based on diagnosis or verification by healthcare provider, or laboratory evidence of immunity (antibody titer). Documentation entered in the medical record and Service immunization database is required.

(6) Tetanus-Diphtheria (TD) or Tetanus-Diphtheria acellular Pertussis (TDaP) in past 10 years. One dose of either is required every 10 years or sooner as indicated. TDaP has replaced TD as the preferred vaccination. TDaP can be administered regardless of interval since the last Tetanus or Diphtheria vaccination, particularly during Pertussis outbreaks.

(7) Influenza vaccine (current seasonal vaccine) is mandatory.

(8) Pneumococcal vaccine. Recommended for smokers, asplenic (no spleen) personnel, and personnel with otherwise compromised immune systems or with high risk health conditions, including chronic heart, lung, liver or kidney disease, and diabetes mellitus. One re-vaccination five or more years after initial pneumococcal vaccination is recommended for functional (sickle cell disease) or anatomic asplenia and immunocompromised conditions. See current CDC guidelines for further details.

(9) Typhoid vaccine (injectable or oral), current per package insert within two years for injectable or five years for oral.

(10) Japanese Encephalitis vaccine. Japanese Encephalitis Virus (JEV) vaccine is required for service members, specifically rotational forces, spending more than 30 days in an austere field environment during the JEV transmission season, or if there is evidence of a JEV outbreak.

(11) Anthrax and Smallpox.

(a) Active duty and EEC per DoD Memo, Expansion of Force Health Protection Anthrax and Smallpox Immunization Programs for Emergency-Essential and Equivalent Department of Defense Civilian Employees, 22 Sept 2004, permanently assigned to USFK and its Service Components, deployed personnel and those on TDY/TAD for greater than 15 consecutive days are required to be vaccinated against anthrax and smallpox.

(b) Per USD/HA (P&R) Memo, Change in Policy for Pre-Deployment Administration of Anthrax and Smallpox Vaccinations, 10 September 2007 vaccinations against anthrax and smallpox can begin up to 120 days prior to scheduled departure date. The reporting member must have received at least two anthrax doses of the five dose series administered before reporting, or be compliant with the dosing schedule. A current smallpox vaccination (or 10 year booster) is required in order to be medically ready (or appropriate medical and/or administration exemption documented in the health record). Individuals having administrative contraindications for the smallpox vaccination (e.g. household transmission of vaccinia virus from contact with smallpox

vaccine) may be allowed to depart unvaccinated but will be vaccinated upon check-in/arrival at the supporting medical unit or at the RSOI site if the capability exists to safely provide the vaccination. Smallpox screening questionnaire must be included as part of the DD Form 2766, Deployed Medical Record. Follow current DoD and Service guidance on immunization waiver requests and adverse vaccine event reporting.

(12) Rabies. Pre-exposure rabies vaccine series for Joint Special Operations Forces (JSOF) is directed per Special Operations Command, Pacific (SOCPAC) FHP guidance. The pre-exposure vaccine series is required for veterinary workers, other high-risk occupational specialties and those involved in prolonged outdoor activities in remote areas where rabies transmission has known to exist.

Table 2-1
Summary of Immunization Requirements

Mandatory (M), Recommended (R), High Risk (HR), Available (A)

Immunization	*Active Duty*	*EEC (DoD and Contractors)*	*DoD Civilians*
Anthrax	M	M	A
Smallpox	M	M	A
Hepatitis A	M	M	A
Hepatitis B	M	HR	HR
Influenza	M	R	R
Measles	M	R	R
Mumps	M	R	R
Rubella	M	R	R
Polio	M	R	R
Tetanus	M	M	R
Diphtheria	M	M	R
Typhoid	M	R	A
JEV*	HR	HR	HR
Varicella**	M	M	R
Pneumococcal	HR	HR	HR
Rabies	HR	HR	HR

*Required for rotational forces operating in austere environments for >30days in known JEV transmission areas.
**Required for personnel without documented evidence of immunity.

c. Force Health Protection Prescription Products (FHPPP).

(1) Malaria.

(a) Chemoprophylaxis is not required for USFK personnel based on the rate and distribution of malaria during CY2012 and CY2013. Upon conference of the FKSG, Component or JTF Surgeons may recommend chemoprophylaxis at any time for those units where the risk of malaria, and its impact on mission accomplishment, is deemed critical. The decision to implement chemoprophylaxis for USFK personnel residing or training in malaria high-risk areas will be made, if warranted, by the consideration of the factors listed below and in paragraph 3-1, Disease Threats and Countermeasures.

(b) The decision to utilize chemoprophylaxis against malaria is made based on: 1) the known rates of malaria transmission in a particular area, 2) the rate of vector mosquitoes positive for the parasite, 3) the ability to implement and actual implementation of PPM, and 4) the impact on mission accomplishment if a service member is infected with malaria.

(c) Chloroquine Chemoprophylaxis.

- If chemoprophylaxis becomes warranted then one chloroquine tablet (500 mg) will be administered weekly starting one week before 1 May and continue until four weeks after 30 October, or, one week before training in a malaria high-risk area and continue until four weeks after 30 October. For individuals and/or units departing the ROK, chloroquine will be taken four weeks after departing the KTO.

- One 100mg tablet of Doxycycline may be taken daily for those unable to take chloroquine. Doxycycline should not be given to pregnant or nursing women.

(d) Terminal Chemoprophylaxis with Primaquine.

- Personnel required to take chloroquine or doxycycline must also take primaquine to eliminate P. vivax parasites that may be present (latent) in the liver. The primaquine regimen will start on or about 1 November or two weeks immediately prior to personnel permanently leaving the high-risk area. Primaquine is taken daily as a single tablet for 14 consecutive days.

- Individuals who are glucose 6 phosphate dehydrogenase (G6PD) deficient should not take primaquine. All Service members found to be deficient in G6PD will be counseled regarding the importance of using personal protection measures (PPM).

(2) Medical CBRN Defense Measures (MCDM).

(a) Rotational and deployed forces and individuals traveling or deploying to the KTO for 30 days or greater are required to bring and maintain appropriate medical countermeasures such as chemical warfare antidotes and antimicrobial prophylaxis/post-exposure medicines. To protect against CBRNE threats within the KTO, deploying units will ensure the availability of the following types and quantities of MCDM:

- Antidote treatment nerve agent auto-injector (ATNAA) (6505-01-362-7427); three each per deploying individual.

- Diazepam injection (convulsant antidote nerve agent - cana) (6505-01-274-0951); one each per deploying individual.

- M291a skin decontamination kit or reactive skin decontamination lotion (RSDL). One M91a kit or one pouch containing 3 packets of RSDL per deploying individual.

- Units will have available either ciprofloxin 500mg tabs or doxycycline 100mg tabs; six tabs per deploying individual of either medication (regardless of choice, ensure adequate supply of second medication to accommodate intolerance to the drug of first choice). This covers an initial dosage to support prophylaxis and/or treatment for three days per individual.

- Individual deployers receiving MCDM items during pre-deployment processing should turn-in these items to their unit upon arrival in the KTO.

(b) To protect against possible and potentially indicated CBRN threats within the KTO, Service Components will acquire and issue, IAW Service policy or on order from the USFK

Commander, the following types and quantities of MCDM items for their forces currently assigned on the Korean Peninsula:

- Pyridostigmine bromide (pb) 30mg tabs (soman nerve agent pretreatment pyridostigmine - snapp); 42 tablets per deployed individual.

- Potassium iodide (ki) tablets; 14 tabs per deployed individual.

- Service Components and/or JTFs with Base Operating Support (BOS) responsibility for bases in the KTO that are key transportation and logistics nodes will ensure adequate amounts of the MCDM items listed above are pre-positioned and stored to support the transient population that may reside or be present at these locations for any period of time and any individual deployers not attached to a troop unit movement.

(c) The United States Army Medical Materiel Center – Korea (USAMMC-K) at Camp Carroll is the theater lead agent for management and maintenance of MCDM items purchased by Component Services and deploying units. On order by the USFK Commander, USAMMC-K will release MCDM items to units for issue to individuals as directed.

(3) Permethrin treated uniforms:

(a) Permethrin is the most effective treatment available for clothing to reduce vector-borne diseases in the field. Application of pesticides for pest management and disease vector control during military contingency operations, readiness training exercises, and deployments shall be under the overall direction of personnel certified in accordance with Armed Forces Pest Management Board (AFPMB) Technical Guide 36, 3 Oct 2009, DoD 4150.7-P, DoD Pest Management Program, Certification of Pesticide Applicators, DoD 4150.7-M, DoD Pest Management Program, Pest Management Training and Certification.

(b) Personnel shall not use field methods to retreat uniforms that were factory treated with permethrin per EPA requirements.

(c) Ensure that personnel are issued, have purchased or are in possession of at least two new or serviceable sets of factory treated uniforms prior to arriving if operating in austere environments where vector-borne disease are known to exists (see paragraph 3-1 for specific health threats) and where permethrin protection is required. Uniforms which are not factory treated may be treated with the individual dynamic absorption (ida) kit (nsn: 6840-01-345-0237) or 2 gallon sprayer permethrin treatment. A matrix of which uniforms may be effectively treated is available on the Armed Forces Pest Management Board (AFPMB) website; www.afpmb.org/.

2-3. Deployment Limiting Conditions

a. DoDI 6490.07, Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees details specific guidance on deployment eligibility. Deploying personnel with potentially disqualifying medical conditions may need to be evaluated by a specialist to assist in the determination of eligibility.

b. In general, individuals with the following conditions based upon a medical assessment shall not deploy unless a waiver is granted.

(1) Conditions that prevent the wear of required personal protective equipment to include factory treated uniforms.

(2) Chronic conditions that require frequent clinical visits (more than semi-annually) or ancillary tests (more than twice/year), that require evaluation or treatment by medical specialists not readily available in the KTO.

(3) Any unresolved acute illness or injury that would impair duty performance during the duration of the deployment or assignment.

(4) Conditions that could cause sudden incapacitation, certain pulmonary disorders, infectious diseases, sensory disorders and cardiac or vascular disease.

(5) Any dental condition reducing dental readiness below class 2.

c. If a Service Component, Commander or supervisor of DoD personnel (except for SOF personnel) wishes to assign an individual to the KTO for either a deployment, TAD or PCS with a medical condition that could be disqualifying per DoDI 6490.07, Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees, the Commander or supervisor must request a waiver.

(1) When a medical waiver is desired for a Service Member, the waiver request shall be submitted to the Component Surgeon through the individual's servicing military medical unit, with medical input provided by the individual's medical provider. The Component Surgeon will review and forward the request with recommendation to FKSG. In the case of a civilian employee, the waiver request shall be submitted though the individual's personnel office to USFK, FKSG for review, approval, and tracking.

(2) Requests for a waiver shall include a detailed medical evaluation or consultation concerning the medical condition(s). Justification shall include statements indicating service experience, position to be placed in, any known specific hazards of the position, anticipated availability and need for care while deployed or assigned, the benefit expected to accrue from the waiver, the recommendation of the Commander or supervisor, and the reasonable accommodations that can be provided for civilian employees covered by The Rehabilitation Act of 1973, as amended.

(3) For Special Operating Forces (SOF) personnel with any of the conditions listed in Enclosure 3 of DoDI 6490.07, Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees, medical clearance may be granted by the Commander, United States Special Operations Command (CDRUSSOCOM), subject to the approval of the USFK Commander.

Chapter 3
Health Threats and Preventive Medicine Countermeasures

3-1. Disease Threats and Countermeasures
All deploying/rotational forces, TAD/TDY for greater than 30 days and PCS personnel must receive a pre-deployment/pre-travel health threat and countermeasures briefing within 30 days of expected date of arrival to the Korean Peninsula. Per National Center for Medical Intelligence (NCMI), the Republic of Korea (ROK) presents an *Intermediate Risk* for infectious diseases. The overall disease risk may adversely impact mission effectiveness unless FHP measures are implemented. This is a conservative assessment as it's based on expected exposures typical of austere field conditions. Disease and health risks are expected to be lower in armistice while operating in improved garrison or semi-permanent living conditions. Specific health threats assessed as *High*

or *Intermediate Risk* to USFK personnel include:

a. Food and Waterborne diseases. Acute diarrheal (bacterial) diseases (*High Risk*) and Hepatitis A (*Intermediate Risk*) associated with the ingestion of contaminated food and/or water constitutes the greatest immediate infectious disease threat to the force. However, reliable data for bacterial diarrhea are limited. Assessment of risk is based primarily on inconsistent public health infrastructure to ensure safe food and water. All other food and waterborne related diseases are estimated to present a *Low Risk* and considered rare events with negligible adverse effects to the force.

(1) The most significant risk of food and waterborne diseases are associated with consuming food from street vendors. Street food vendors have relatively limited and restricted access to potable water, restrooms, refrigeration, washing and waste disposal facilities.

(2) Caution must be taken before eating street-vended foods. Eat only hot fully-cooked foods and avoid warm, cool, cold, and partially cooked or uncooked items. Self-peeled fruits and vegetables are generally considered safe, but are safest when first sanitized. Street-vended water or other beverages should only be consumed if they come from a sealed container (e.g. bottled water, soda, etc.).

b. Vector-borne Diseases. Ecological conditions in both urban and rural areas support populations of arthropod vectors, including mosquitoes, ticks, mites, and fleas, with variable rates of disease transmission. Malaria, which occurs only in areas along the demilitarized zone (DMZ), and Japanese Encephalitis Virus (JEV) are the major vector-borne risks in the ROK and are capable of debilitating personnel for up to a week or more. In addition, other vector-borne diseases, including Hantavirus, and several tick-borne diseases are transmitted at varying levels. Avoidance of vectors is key, including habitat awareness, proper wear of uniform/other clothing, and use of preventive measures. Vector-borne disease overall represent an *Intermediate Risk* to forces.

(1) Malaria.

(a) USFK Regulation 40-2, Prevention, Surveillance, Diagnosis, Treatment and Reporting of Vivax Malaria in the Republic of Korea is the USFK malaria prevention guidance and applies to all Service Components, major subordinate commands (MSC) and all units and individuals deploying to KTO.

(b) *Plasmodium vivax* (*P. vivax*) is the only naturally occurring human malaria in the ROK. Its transmission is limited to the warmer months (primarily March – December) with the period of greatest risk of malaria infection occurring between May and October in rural areas in the northern parts of Incheon, Kangwon-do, and Kyonggi-do Provinces to include areas proximate to the DMZ.

(c) Malaria chemoprophylaxis is not universally required for USFK personnel but may become mandatory for forces operating in high risk areas south of the DMZ (see figure 3-1 below). If antimalarials are warranted then chemoprophylaxis requirements per paragraph 2-2c applies.

(2) Japanese Encephalitis Virus (JEV).

(a) JEV is endemic throughout the ROK and most prevalent in rural and rice-growing or flooded agricultural areas in proximity to swine populations (see figure 3-2 below). The highest risk period is between May and October.

(b) PACOM FHP Guidance of October 2013 and this regulation requires JEV vaccine for forces operating more than 30 days in the field in an agrarian environment, or if there is evidence of a JEV outbreak. In addition, Component and JTF medical departments must monitor JEV rates closely in consultation with the FKSG and the ROK Army's Armed Forces Medical Command (AFMC).

Figure 3-1. Plasmodium Vivax Distribution

Figure 3-2. JEV Distribution

(3) Component and JTF surgeons are encouraged to conduct evidence-based entomological and epidemiological assessments of malaria and JEV risk at fixed bases where significant numbers of personnel are assigned for prolonged periods. In conducting such a risk assessment, Surgeons should review the most recent assessments and risk maps produced by the NCMI. This information can be accessed on unclassified website https://www.intelink.gov/ncmi/index.php. Products can also be accessed on SIPRNET website http://www.afmic.dia.smil.mil. Based on NCMI risk assessments, recommendations for modified chemoprophylaxis and vaccination policy will be provided to Commanders using the following guidelines.

(a) Areas where the projected attack rates are 1-10 percent per month or greater: chemoprophylaxis or vaccination is required.

(b) Areas where the projected attack rate is "a small number of cases (less than 1 per 100 per month)": malaria chemoprophylaxis or vaccination is generally indicated for field operations and rural exposures.

(c) Areas where NCMI assesses the projected attack rate to be "rare cases (less than 1 per 1000 per month)", chemoprophylaxis or vaccination is not always Indicated. Personal protective measures may provide sufficient protection.

(4) Personal Protective Measures. In addition to malaria and JEV, an *Intermediate Risk* of disease caused by insects and ticks (specifically, Tick-Borne encephalitis, Lyme disease, Flea-borne Typhus) exist year-round in the KTO. The threat of disease will be minimized by using permethrin impregnated field uniforms, permethrin impregnated bed nets (during field exercises), proper wear of uniforms, and effective insect repellents (e.g., DEET 20-33% formulations) applied to exposed skin. It is the unit responsibility to order repellents through the Defense Logistics Activity (DLA) and maintain sufficient supplies for operational and field training exercises.

c. Soil and Water Contact-Diseases of Concern.

(1) Hantavirus hemorrhagic fever with renal syndrome (HFRS) presents a *High Risk* to forces who are exposed to dust or aerosols in rodent-infected areas. Cases occur year round, however a consistent increase in transmission exists between September and December, which correspond closely with peaks in rodent infection. Every reasonable effort should be made to minimize exposure to the virus in the environment. Rodent management practices and/or avoidance of habitats are strongly recommended. If rodent feces or nesting material are encountered, N-95 fit-tested respirators and gloves must be worn. Clean-up should be conducted using a wet method with a diluted bleach solution. USFK Regulation 40-1, Prevention, Surveillance and Treatment of Hemorrhagic Fever with Renal Syndrome (HFRS) details the USFK policy on prevention, surveillance and treatment of HFRS and should be followed to the maximum extent possible.

(2) Leptospirosis occurs country-wide and risk varies by location with increased transmission during flooding. NCMI assesses an *Intermediate Risk* to forces specifically among personnel exposed (wading or swimming) to bodies of water contaminated with the agent responsible for the disease, which is shed in the urine of infected rodents, livestock and other animals. Likelihood of disease depends on amount of exposure to the agent in surface water. Doxycycline prophylaxis may be considered if contact with potentially contaminated water is unavoidable due to training or operational requirements.

(3) Bodies of surface water are likely to be contaminated with human and animal waste.

Activities such as wading or swimming may result in exposures to enteric diseases such as diarrhea and hepatitis via incidental ingestion of water. Prolonged water contact also may lead to the development of a variety of potentially debilitating skin conditions such as bacterial or fungal dermatitis.

d. Respiratory Diseases.

(1) Korea is assessed as an *Intermediate Risk* country for TB per NCMI. However, based on steadily increasing incidence of active disease, with a corresponding increase in new latent TB infections (LTBI) among the USFK population, the USFK Command Surgeon estimates a higher true risk to personnel. Country-wide rates for active disease per 100,000 have increased from 65 in 2004 to 78.5 in 2012. Based on Korean Center for Disease Control and Prevention (KCDC) data, the potential risk of exposure to active TB is greater in the ROK (78.5/100,000) than in the United States (3.2/100,000) (CDC, 2012). The actual case reporting of new LTBI among the USFK population is rising from 1.3 in January 2010 to 6.2 in Oct 2013. For this reason, a more conservative approach to TB screening is recommended per this regulation.

(2) Although not specifically addressed in this document, USFK personnel may be exposed to wide variety of common respiratory infections in the local population including; influenza, pertussis, viral and bacterial upper respiratory infections and pneumonia. Influenza is of particular concern because of its ability to debilitate large numbers of unvaccinated personnel for several days.

e. Sexually Transmitted Infections.

(1) Sexually Transmitted Infections (STI) are an *Intermediate Risk* (Gonorrhea, Chlamydia, HIV/AIDS, Hepatitis B). Abstinence is the only way to ensure complete prevention of an STI. Latex condoms should be made available and used by all choosing to be sexually active.

(2) Personnel shall seek prompt medical treatment if STI symptoms occur. HIV post-exposure prophylaxis after high risk sexual exposure may be appropriate if within 72 hours of exposure. Members treated for presumed STI shall have an HIV test conducted at a MTF capable of performing the test, when laboratory assets become available, or, for deployed personnel, immediately upon redeployment. Additional testing may be indicated based on clinical judgment.

3-2. Environmental Health Threats and Countermeasures

All deploying/rotational forces, TAD/TDY and PCS personnel must receive a pre-deployment/pre-travel health threat and countermeasures briefing within 30 days of expected date of arrival to the Korean Peninsula. National Center for Medical Intelligence (NCMI), assesses the environmental health risks for the ROK as *Low* to *Intermediate.* The overall environmental health risk may adversely impact mission effectiveness unless FHP measures are implemented. This is a conservative assessment as it's based on expected exposures typical of austere field conditions. Disease and health risks are expected to be lower in armistice while operating in improved garrison or semi-permanent living conditions. Table 3-1 summarizes the specific environmental health threats. This Regulation only addresses threats assessed as *Intermediate Risk* (or above) to USFK personnel.

Table 3-1
Assessed Environmental Health Risks by Media

Media	Risk	Typical Period	Typical Severity	Probability / Likelihood
Water	Intermediate	All Year	Moderate	Occasional
Physical	Intermediate	July-August	Moderate	Occasional
Air	Intermediate	All Year	Moderate	Occasional
Food	Intermediate	All Year	Moderate	Occasional
Soil*	Low	All Year	Low	Rare

* Acute and chronic health risks associated with exposure to soil is not addressed due to the low likelihood of a significant event.

a. Water.

(1) The NCMI judges the consumption of water in the ROK to pose an *Intermediate* human health risk because of contamination with fecal pathogens as well as contamination from uncontrolled industrial waste disposal. Personnel consuming water from local water sources may occasionally be exposed to microbial or chemical contaminants and experience health effects of moderate severity. The quality of municipal water sources is likely higher in urban areas such as Seoul.

(2) Municipal drinking water in urban areas throughout the country, including Seoul, Kunsan, and Busan is potable. Joint civil and government organizations are responsible for water quality sampling in Seoul and other cities and treated water is tested daily for quality standards including color, odor, taste, pH, turbidity, and residual chlorine. According to government data from April through May 2013, treated water in urban areas is considered safe by the U.S. Environmental Protection Agency (EPA) drinking water standards.

(3) Policies and procedures for source selection, treatment, surveillance and distribution of tactical water supplies are detailed in Tri-Service Technical Bulletin, 1 May 2010, Sanitary Control and Surveillance of Field Water Supplies and must be strictly followed to guarantee the safety of troop water supplies while operating in field conditions.

b. Physical.

(1) NCMI assesses floods and landslides pose an *Intermediate* health risk and can result in mortality, trauma, asphyxia, and/or loss of basic services (water and sanitation). Additionally, physical hazards exist from heat and/or weather and pose a *Low* health risk.

(2) The ROK averages monthly temperature of minus 5 degrees C (23 degrees F) in January and 26 degrees C (79 degrees F) in August. In Busan, the average January temperature is 3 degrees C (37 degrees F). In Seoul, extreme temperatures occasionally reach 38 degrees C (100 degrees F) in August and minus 24 degrees C (minus 12 degrees F) in December. USKF personnel and incoming units must take appropriate precautions regarding exposure to extreme heat/humidity, snow and cold temperatures. Heat illnesses and cold weather injuries are the greatest physical risks encountered by USFK personnel, particularly while conducting operations outdoors.

c. Air Contamination.

(1) Localized air contamination in the ROK poses a *Low* to *Intermediate* health risk. Personnel may be occasionally exposed to air pollution levels exceeding U.S. recommended

guidelines; however, only minor health effects are expected. Occasional periods of reduced air quality in urban areas due to heavy vehicular traffic, industrial emissions, and from trans-boundary dust ("Yellow Sand") may cause short-term health effects, particularly in sensitive individuals. Pollutants of concern include particulate matter, sulfur dioxides, and nitrogen oxides; personnel may experience increased respiratory illnesses or transient acute respiratory effects such as coughing, wheezing, and reduced lung function from such pollutants. Urban areas of concern include but are not limited to Seoul, Busan, and Pohang.

(2) Trans-boundary air pollution, specifically particulate matter, adversely impacts the air quality. The long-range transport of yellow sand from the Gobi Desert and the Mongolian plateau in the spring (March to May) and the impacts from China's industrial regions may cause short term health affects in sensitive individuals. Periods of elevated air pollution in China occasionally impacts Seoul, resulting in a reported peak particulate matter with an aerodynamic diameter of 10 micrometers or less (PM-10) of 218 micrograms per cubic meter, well above the Environmental Protection Agency's (EPA) National Ambient Air Quality Standards (NAAQS) of 150 micrograms per cubic meter. USFK Regulation 40-6, Yellow Sand Activity Monitoring System details policies and procedures governing the Yellow Sand Activity Monitoring System, which is designed to implement protective procedures and activity restrictions recommendations during high concentrations of Yellow Sand.

d. Food Contamination.

(1) Food contamination presents an *Intermediate* human health risk. Individuals regularly eating on the local economy (specifically street food vendors) will occasionally be exposed to microbial and chemical contaminants in food, typically at levels likely to result in moderate health effects, to include gastrointestinal illness and diarrhea.

(2) Food (and water) vulnerability assessments and food safety surveillance are conducted IAW Joint Service Standards for all garrison establishments and facilities. Field food service operations require a higher level of conformance with food safety requirements to include provision of food and water form approved sources, to prevent a loss of combat effectiveness.

(3) Component Commanders must enforce the use of all required countermeasures including the use of DoD Approved Sources of food and bottled water IAW Tri-Service Food Code, 7 Oct 2013. When requesting DoD Approved Source Audits of food establishments ensure enough lead time (typically 3-6 months) in order to meet the operational and logistical requirements of the mission. Audit requests will meet requirements set forth by the U.S. Army Veterinary Service Activity and may be found at www.veterinaryservice.army.mil/food.html.

(4) Component Commanders are responsible for ensuring food and water vulnerability assessments are conducted IAW Service Standards to validate potential or actual vulnerabilities and determine courses of action to control or reduce the vulnerabilities. Food and water vulnerability assessments must be done in collaboration with security, medical, and anti-terrorism personnel.

Chapter 4
FHP Summary of Requirements during Deployments

4-1. FHP during Deployments
This paragraph contains a summary of FHP activities that are required during deployment per JCS MCM 0028-07, Procedures for Deployment Health Surveillance, 2 November 2007, DoDD

6200.04, Force Health Protection, DoDI 6490.03, Deployment Health. Not all deployment health activities noted in those references will apply to the KTO during armistice but are included here for planning purposes only. The USFK Commander will direct the USFK Command Surgeon to publish enhanced FHP requirements (during deployment) as dictated by the operational environment.

a. For land-based deployments or travel, for 30 days or more to the KTO, Commanders and/or medical personnel must conduct daily disease and injury (DI) surveillance, disease and injury reporting, and other activities to detect any trends in health of deployed personnel as outlined below.

(1) Medical personnel must conduct ongoing health surveillance, pesticide, sanitation and food service surveillance, location specific occupational environmental health site assessment (OEHSA) and systemic OEH hazard surveillance.

(2) Surveillance data is reported and archived according to DoD and Service specific policies. The Defense Occupational and Environmental Health Readiness System (DOERHS) per DoDI 6490.03, Deployment Health will be used to capture all OEH exposure data.

(3) During deployment, medical personnel will:

(a) Validate and update preliminary hazard assessment.

(b) Ensure environmental monitoring of air, water, soil, disease vectors, and radiation based on assessment of actual and/or potential medical threats at deployed locations.

(c) Ensure deployment health surveillance and OEH reporting and data submission, data summaries, final reports and investigations to USAPHC via DESP and DOEHRs for further disposition and archiving. Alert USFK, Service Chain of Command, Armed Forces Health Surveillance Center (AFHSC), and NCMI to any newly identified health threats, negative health trends or adverse events.

(d) Investigate, report and document all OEH and chemical, biological, radiological and nuclear (CBRN) exposure incidents.

(e) Document OEH surveillance and monitoring summaries for each permanent or semi-permanent basing location and update at least annually. File the OEH summaries in the medical records of each individual for which exposure applies or archive the summaries so that they are readily available to health care providers and redeployed personnel.

(4) Deployed medical personnel at each operating location must conduct ongoing DI surveillance through DoD and Service specific automated systems.

(5) Conduct pest control operations using the integrated pest management concept described in Armed Forces Pest Management Board (AFPMB) Technical Guide 36, 3 Oct 2009, current AFPMB recommendations and IAW Service policy. Vector surveillance and control must be a part of all operational planning.

b. For any land-based deployment or travel, Commanders and/or medical personnel must:

(1) Ensure appropriate storage, use and disposal of hazardous materials.

(2) Ensure the integrity of field hygiene and sanitation, occupational health and safety programs.

(3) Enforce the use of all required countermeasures including the use of DoD approved sources of food and bottled water and personal protective equipment to protect the health of personnel, balanced with mission needs.

4-2. Disease and Injury Surveillance

Disease and injury event trends, whether counts or rates, are an important type of surveillance for use at all levels and must be monitored and evaluated daily during deployment. Abnormal patterns or trends may indicate a problem that could negatively impact mission accomplishment and the need for additional investigations, and if validated, the need to implement appropriate FHP countermeasures.

a. Component and JTF Surgeons are responsible for ensuring that units deployed to the KTO are collecting the prescribed DI data and reporting that data through manual surveillance procedures since the Joint Medical Workstation (JMeWS) is not a viable data collection system for the KTO. Instead, medical personnel will need to revert to manual surveillance procedures and submit a weekly summary report of DI surveillance rates via secure communication (CENTRIX-K) to their Chain of Command and to the USFK Command Surgeon.

b. At least daily, medical personnel at all levels will analyze the DI data from deployed units and make changes and recommendations as required to reduce DI and mitigate the effects upon operational readiness. The list of DI reporting categories, their definitions, and the essential elements of the standard DI report can be found in DoDI 6490.03, Deployment Health and DoDI 6490.02, Comprehensive Health Surveillance.

c. Component, Subordinate Command and JTF Surgeons are responsible for ensuring that units are collecting the appropriate reportable medical event (RME) data and reporting that data through their Service-specific reporting mechanisms. Suspected or confirmed RMEs should be reported to USFK Command Surgeon as appropriate.

4-3. Documentation of OEH Monitoring Data

Ensure Periodic Occupational and Environmental Monitoring Summaries (POEMS) are developed per JCS MCM 0028-07, Procedures for Deployment Health Surveillance, 2 November 2007, DoDD 6200.04, Force Health Protection, DoDI 6490.03, Deployment Health, PACOM FHP Guidance of October 2014, DoDI 6490.02, Comprehensive Health Surveillance for each permanent or semi-permanent basing locations in support of the full range of USFK mission to include; combat operations, peacekeeping, deterrence operations, and disaster relief. The POEMS, when required to be completed, should be updated annually.

a. Certain information will be provided by field personnel at the site being evaluated, however the POEMS will generally be created by specialized technical support units (e.g., specialized deployable teams/units, USAPHC, Navy and Marine Corp Public Health Center (NMCPHC), U.S. Air Force School of Aerospace Medicine (USAFSAM))—especially for the description of long-term health risks and the assessment of laboratory data that requires a level of technical expertise and resources not always available in the field.

b. Component medical departments and Service Component Surgeon's Office can review completed POEMS on the DoD environmental exposure data portal (https://doehsportal.apgea.army.mil/doehrs-oehs).

4-4. Occupational and Environmental Health Site Assessments
Conduct as required by the USFK Commander to document the OEH conditions found at a site (base camp, bivouac site or outpost, or other permanent or semi-permanent basing location) beginning at or near the time it is first occupied. The assessment, should be initiated by Component Service preventive medicine personnel and includes site history; environmental health survey results for air, water, soil, and noise; entomological surveys; occupational and industrial hygiene surveys; and ionizing and non-ionizing radiation hazard surveys, if indicated.

a. The OEHSA is an iterative evaluation built on a conceptual site model of the deployed location that seeks to link areas and contaminants of concern to harmful exposures to operational forces. The goal of these comprehensive assessments is to identify actual or potential completed exposure pathways for chemical, biological, and radiological agents in the environment that may affect the short or long-term health of deployed personnel.

b. An exhaustive outline, process and methodology for conducting OEHSA is not addressed in this regulation. Additional guidance will be developed as determined by the FKSG based on the operational environment and ongoing assessment of OEH risks.

Chapter 5
Post-Deployment FHP and Health Surveillance Activities

*Post-Deployment. Services are responsible for ensuring post deployment activities per this regulation are accomplished.

a. The following must be accomplished for personnel who deployed or traveled for 30 or more days to a land-based location within the KTO.

(1) Individuals indicated for terminal primaquine prophylaxis (those deployed to malaria risk area) will see a licensed medical provider prior to starting on primaquine. The provider will review the person's G6PD test status and result, and then prescribe a primaquine dosing regimen IAW current CDC, FDA and clinical practice guidelines that is tailored to that person.

(2) When required, receive a medical threat debrief and complete post-deployment health assessment questionnaire (DD Form 2796) within 30 days on either side of redeployment, and for reserve component members, before they are released from active duty; and complete the additional post-deployment health reassessment (PDHRA) 90-180 days after redeployment using DD Form 2900 (or automated equivalent) IAW JCS MCM 0028-07, Procedures for Deployment Health Surveillance, 2 November 2007.

(a) Integrate the DD Forms 2766 and copies of the DD Forms 2795 and 2796, documentation of theater inpatient and outpatient health care encounters, the POEMS, and incident documentation with the individuals' permanent medical health records within 30 days of redeployed personnel returning to a demobilization site or home station.

(b) For Reserve Component members, these records should be returned to the medical record custodian at the member's Reserve unit of assignment.

(3) Ensure that significant occupational and environmental health related events/exposures are included in operational After Action Reports (AARs). This shall include any disease outbreaks, location of industrial sources, contaminated sites, presence of disease vectors, and other

operational factors that affected the overall health experience (acute, chronic, or latent effects) of the deployed Service members.

(4) Ensure electronic copies of each are transmitted to the DMSS at the AFHSC. Ensure appropriate medical follow-up as required.

(5) Conduct TB exposure testing within 90 days after returning to home station.

(6) Draw post-deployment serum samples at home station for storage in the serum repository IAW current DoD and Service-specific policy.

(7) Integrate all deployed medical encounter documentation into the medical record.

(8) Ensure all health surveillance and OEH monitoring data and reports have been submitted to the AFHSC and DOEHRS data portal.

b. Medical personnel will conduct and submit all lessons learned and AARs IAW Service-specific and subordinate activity policy or to the Joint Center for Lessons Learned for joint deployments. All lessons learned and AARs will be submitted to the servicing component and a copy furnished to the FKSG for situational awareness.

Appendix A
References

JCS MCM 0028-07, Procedures for Deployment Health Surveillance, 2 November 2007.

DoDD 6200.04, Force Health Protection.

DoDI 6490.03, Deployment Health.

PACOM FHP Guidance of October 2013.

DoDI 6490.02, Comprehensive Health Surveillance.

USFK Regulation 40-7, Individual Medical Readiness(IMR).

DoDI 6025.19, Medical Readiness.

DoDI 6490.13, Comprehensive Policy on Neurocognitive Assessments by the Military Services.

DoDI 6490.07, Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees.

DoD Memo dtd 22 Sept 2004, Expansion of Force Health Protection Anthrax and Smallpox Immunization Programs for Emergency-Essential and Equivalent Department of Defense Civilian Employees.

USD/HA (P&R) Memo, Change in Policy for Pre-Deployment Administration of Anthrax and Smallpox Vaccinations10 September 2007.

Armed Forces Pest Management Board (AFPMB) Technical Guide 36, 3 Oct 2009.

DoD 4150.7-P, DoD Pest Management Program, Certification of Pesticide Applicators.

DoD 4150.7-M, DoD Pest Management Program, Pest Management Training and Certification.

USFK Regulation 40-2, Prevention, Surveillance, Diagnosis, Treatment and Reporting of Vivax Malaria in the Republic of Korea.

USFK Regulation 40-1, Prevention, Surveillance and Treatment of Hemorrhagic Fever with Renal Syndrome (HFRS).

Tri-Service Technical Bulletin, 1 May 2010, Sanitary Control and Surveillance of Field Water Supplies.

USFK Regulation 40-6, Yellow Sand Activity Monitoring System.

Tri-Service Food Code, 7 Oct 2013.

Glossary

Section I. Abbreviations

7th AF	Seventh Air Force
AAR	After Action Report
AFMC	Armed Forces Medical Command
AFHSC	Armed Forces Health Surveillance Center
AFPMB	Armed Forces Pest Management Board
BOS	Base Operating Support
CBRN	Chemical, Biological, Radiological, Nuclear
CNFK	Commander, Naval Forces Korea
DESP	Deployment Environmental Surveillance Program
DI	Disease and Injury
DNA	Deoxyribonucleic Acid
DOEHRS	Defense Occupational and Environmental Health Readiness System
DOD	Department of Defense
DMSS	Defense Medical Surveillance System
EEC	Emergency Essential Civilian
EPA	Environmental Protection Agency
FHP	Force Health Protection
FHPPP	Force Health Protection Prescribed Products
FKSG	Office of the Command Surgeon, USFK
G6PD	Glucose-6-Phosphate Dehydrogenase
GCC	Ground Component Command
HIV	Human Immunodeficiency Virus
HFRS	Hantavirus Hemorrhagic Fever with Renal Syndrome
HSS	Health Services Support

IMR	Individual Medical Readiness
IPV	Inactivated Polio Vaccine
JEV	Japanese Encephalitis Virus
JMeWS	Joint Medical Workstation
JUPITR	Joint USFK Portal and Integrated Threat Recognition
JPRC	Joint Personal Reception Center
LTBI	Latent Tuberculosis Infection
MARFOR-K	US Marine Forces Korea
MCDM	Medical CBRN Defense Measures
MMR	Measles, Mumps and Rubella
MTF	Military Treatment Facility
NAAQS	National Ambient Air Quality Standards
NMCPHC	Navy and Marine Corps Public Health Center
NCMI	National Center for Medical Intelligence
OEH	Occupational Environmental Health
OEHS	Occupational Environmental Health Surveillance
OEHSA	Occupational Environmental Health Site Assessment
PCS	Permanent Change of Station
PHA	Periodic Health Assessment
PPD	Purified Protein Derivative
PPM	Parts Per Million
RSOI	Reception Staging Onward Integration
SOF	Special Operating Forces
STI	Sexually Transmitted Infections
TAD	Temporary Assigned Duty
TB	Tuberculosis

Td/Tdap	Tetanus, Diphtheria, and Acellular Pertussis
TDY	Temporary Duty
TST	Tuberculin Skin Test
U.S.	United States
USFK	United States Forces Korea
USAFSAM	United States Air Force School of Aerospace Medicine
USAMMC-K	United States Army Medical Materiel Center - Korea
USAPHC	United States Army Public Health Command

Section II. Terms

Chemical, Biological, Radiological, and Nuclear (CBRN). For the purposes of this regulation, specific warfare agents that pose health threats such as toxic chemicals intended for use in military operations; microorganisms that cause disease in personnel, plants, or animals or causes the deterioration of material; toxins; or agents that emit radiation, generally alpha or beta particles, often accompanied by gamma rays, from the nuclei of an unstable isotope.

Chemoprophylaxis. The administration of a chemical agent to prevent the development of diseases.

Comprehensive Military Health Surveillance. Health surveillance conducted throughout Service members' military careers and DoD civilian employees' employment, across all duty locations, and encompassing risk, intervention, and outcome data. Such surveillance is essential to the evaluation, planning, and implementation of public health practice and prevention and must be closely integrated with the timely dissemination of information to those who can act upon it.

Deployment Health Activities. The regular collection, analysis, archiving, interpretation, and distribution of health-related data used for monitoring the health of individuals or a deployed population, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury. It includes OEH and medical surveillance subcomponents.

DMSS. An executive information system whose database contains up-to-date and historical data on diseases and medical events (e.g., hospitalizations, ambulatory visits, reportable diseases, Human Immunodeficiency Virus tests, acute respiratory diseases, and health risk appraisals) and longitudinal data on personnel and deployments.

Exposure. Human contact due to a completed exposure pathway with a hazardous or potentially hazardous chemical, physical, or biological agent. Exposure may be short-term, of intermediate duration, or long-term. Assessment of individual health risk is dependent on the exposure concentration (how much), the frequency and duration of exposure (how long), and the multiplicity of exposures with other similar exposure agents.

Food and Water Vulnerability Assessments. Assessments of the susceptibility of food and water (from the point of manufacture/packaging, through distribution, storage, preparation, and

serving), including ice and bottled water supplies, to natural or intentional contamination or destruction including terrorist attacks.

Force Health Protection (FHP). For purposes of this regulation, it includes all measures taken by commanders, supervisors, individual service members, and the military health system to promote, protect, improve, conserve, and restore the mental and physical well-being of service members across the full range of military activities and operations. These measures enable the fielding of a healthy and fit force, the prevention of injuries and illness, and protection of the force from health threats; and the provision of highly effective medical and rehabilitative care to those who become sick or injured.

FHPPPs. Certain drugs, vaccines, and other medical products useful for protecting the health of deployed personnel that may be used only under a physician's prescription. Examples of such products are atropine and/or 2-Pam chloride auto-injectors, certain antimicrobials, antimalarials, and pyridostigmine bromide.

Glucose-6-Phosphate Dehydrogenase (G6PD). An X-linked (related to the chromosomal gender of the individual) recessive hereditary disease featuring abnormally low levels of the G6PD enzyme, which plays an important role in red blood cell function. Individuals with the disease may exhibit non-immune hemolytic anemia (break down of red blood cells) in response to a number of causes.

Health Surveillance. The regular or repeated collection, analysis, and interpretation of health-related data and the dissemination of information to monitor the health of a population and to identify potential health risks, thereby enabling timely interventions to prevent, treat, reduce, or control disease and injury. It includes occupational and environmental health surveillance and medical surveillance subcomponents.

Occupational and Environmental Health Site Assessment. Documents the OEH conditions found at a site (base camp, bivouac site or outpost, or other permanent or semi-permanent basing location) beginning at or near the time it is first occupied. The assessment, done by Service preventive medicine personnel, includes site history; environmental health survey results for air, water, soil, and noise; entomological surveys; occupational and industrial hygiene surveys; and ionizing and non-ionizing radiation hazard surveys, if indicated. Its purpose is to identify hazardous exposure agents with complete or potentially complete exposure pathways that may affect the health of deployed personnel.

Occupational and Environmental Health Activities. The regular collection, analysis, archiving, interpretation, and dissemination of OEH-related data for the purposes of monitoring the health of or potential health hazard impact on a population or an individual, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury, and to assess the effectiveness of controls.

Occupational and Environmental Health Surveillance. The regular or repeated collection, analysis, archiving, interpretation, and dissemination of occupational and environmental health-related data for monitoring the health of, or potential health hazard impact on, a population and individual personnel, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury when determined necessary.

Immunization. The process of rendering an individual immune to specific disease-causing agents. Immunization most frequently refers to the administration of a vaccine to stimulate the immune system to produce an immune response.

Individual Medical Readiness (IMR). The extent to which a service member is medically ready to participate in the full range of military activities and operations—to include operational deployments, as measured by six key elements: a current periodic health assessment; the absence of deployment-limiting health conditions; a favorable dental readiness classification; currency in required immunizations; the completion of readiness-related laboratory studies; and the availability of individual medical equipment.

Medical Surveillance. The ongoing, systematic collection, analysis, and interpretation of data derived from instances of medical care or medical evaluation, and the reporting of population-based information for characterizing and countering threats to a population's health, well-being, and performance.

Periodic Health Assessment (PHA). An annual assessment for changes in health status, especially those that could impact a member's ability to perform military duties.

Preliminary Hazard Assessment (PLHA). For the purposes of this Instruction, PLHA is the process of reviewing relevant intelligence data, past hazard assessments, and/or other available pre-deployment data for the area of deployment to identify potential OEH threats to deploying personnel.

Vaccination. The administration of a vaccine to an individual for inducing immunity.

Vaccine. A preparation that contains one or more components that when administered, induces a protective immune response against a pathogen (infectious agent).